# HEALTH FINANCE COMMISSION

***Legislative Services Agency***
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## MEETING MINUTES[1]

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| **Meeting Date:** | **September 10, 2007** |
| **Meeting Time:** | **1:00 P.M.** |
| **Meeting Place:** | **State House, 200 W. Washington St., Room 404** |
| **Meeting City:** | **Indianapolis, Indiana** |
| **Meeting Number:** | **3** |

**Members Present:** **Sen. Beverly Gard; Sen. Vaneta Becker; Sen. Connie Lawson; Sen. Ryan Mishler; Sen. Earline Rogers; Sen. Connie Sipes; Sen. Vi Simpson; Rep. Charlie Brown, Vice-Chairperson; Rep. John Day; Rep. Carolene Mays; Rep. Scott Reske; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell.**

**Members Absent:** **Sen. Patricia Miller, Chairperson; Sen. Gary Dillon; Sen. Marvin Riegsecker; Sen. Sue Errington; Rep. Peggy Welch; Rep. Craig Fry; Rep. Phil Hoy; Rep. Don Lehe.**

The third meeting of the Health Finance Commission was called to order by Vice-Chairperson Rep. Charlie Brown at 1:15 PM.

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[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Staff distributed information from the Indiana Tobacco Prevention and Cessation Agency provided in response to Commission questions (Exhibit #1).

**Regulation of Methadone Clinics**

Mr. Joe Pritchard, Indiana Treatment of Opioid Dependency (INTOD)

Mr. Pritchard, representing the INTOD membership which consists of 12 of the 14 methadone clinics in the state, distributed printed information (Exhibit #2) and gave an overview of the methadone treatment program.

*Demographics:* The clinics treat about 12,000 individuals each day; 59% of the treatment population is male, 40% is female. Of the individuals receiving treatment, 71% are employed and approximately 54% are Indiana residents.

*Treatment:* Mr. Pritchard summarized that methadone treatment is the most researched and regulated form of treatment today, and it is the most effective treatment that is currently available. He stated that methadone treatment works, but there are always patients that will relapse. He explained that methadone does not give a 'high' but rather alleviates the euphoric effects of an opiate. Mr. Pritchard emphasized that while methadone is a substitute addiction, it is not a lifelong addiction - only 5% of the treatment population remains on methadone after 5 years. He reported that not everyone that presents at a methadone clinic is appropriate to receive methadone or clinic services. The diagnostic criteria used to determine the appropriate level of care are included in Exhibit #2.

*Efficacy of Treatment:* Mr. Pritchard reported that in Indiana, 68% of patients are still consistently in treatment after one year. He explained that this number is significant since positive impacts of treatment such as maintaining employment are increased by one year spent in treatment. The data also show that after 12 months, fewer than 3% are re-arrested.

*Drug Diversions:* Mr. Pritchard reported that methadone is prescribed outside the clinics; 95% of diverted methadone comes from sources other than methadone clinics. Methadone clinics in Indiana use liquid or a diskette form. Samples of the product and containers were shown to the Commission members. Mr. Pritchard said that clinics provide quality care using credentialed providers. The goal of methadone treatment is to restore patients to society. He invited Commission members to visit a clinic.

*Criminality in Clinics:* In response to complaints that clinic locales have increased crime rates, Mr. Pritchard reported that police department data do not show a correlation of decreases or increases in crime due to clinic openings or closings.

Commission questions followed regarding whether surrounding states had more restrictive practices than Indiana and how the treatment practices in Indiana compare to those in other states. Members were also interested in how the number of clinics per capita of population in Indiana compares to that of other states. The Commission asked about the street value of methadone - not known; the cost of methadone for the clinics - about $0.13 per dose; and the cost of treatment - about $11-$12 per day.

Vidya Kora, MD, Indiana State Medical Association (ISMA)

Dr. Kora, introduced himself as a practicing internist and the LaPorte County Coroner. Dr. Kora reported that of nine recent deaths attributable to methadone, seven had clinic sources and two had outside sources of methadone. He said that methadone is prescribed as an inexpensive treatment for pain. Dr. Kora suggested that patients should be notified that mixing methadone with other drugs or alcohol is dangerous. He explained that when methadone treatment programs were originally set up, the intent was to provide treatment for heroin addiction, not for any opioid addiction. The result of the inclusion of addictions for drugs other than heroin has caused good and bad results for the clinics. Dr. Kora suggested that the for-profit orientation of the majority of the clinics in Indiana does not lend an incentive to get patients off methadone. Dr. Kora stated that he is not opposed to methadone treatment, but that there should be aggressive measures to get patients off the drug. He said he is advocating a different approach. He recommended that the operation of methadone clinics be removed from the for-profit sector and that the clinics be operated by the State Department of Health. (See Exhibit #3.)

Commission questions followed with regard to whether other states operate their clinics.

Debbie Frazier, Columbus, IN

Ms. Frazier related her son's experience as a methadone clinic patient for 2.5 years before his death by overdose. Ms. Frazier questioned the extent of patient oversight and the accountability of the treatment program her son was enrolled in. She stated that she thought the methadone treatment program was an enabler of her son's alternative addiction. Ms. Frazier recommended that the methadone clinics need to develop better programs and be accountable for their results.

John Viernes, Deputy Director, Division of Mental Health and Addiction, FSSA

Mr. Viernes distributed information on patient residency of each clinic. Exhibit #4 shows the total number of patients by clinic and state of residence for CY 2005. Exhibit #5 breaks out the number of out-of-state residents only for each clinic. Exhibit #6 shows the patient population for each clinic by Indiana county of residence for CY 2005. Also distributed was Exhibit #7, a letter from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) regarding initial dosing practices in methadone clinics.

Mr. Viernes reviewed the authorizing statutes and rules that authorize an annual $20 fee for nonresidents receiving methadone treatment. He reported that the Division collected $102,000 this year. This revenue is used to partially fund annual inspection visits of the clinics made by the Division.

Mr. Viernes reviewed four recommendations for the Commission's consideration. (See Exhibit # 8.) The Division recommends: (1) requiring defined staffing ratios of licensed professionals to patients in the clinics; (2) requiring specific licensure of addiction treatment professionals; (3) requiring individualized treatment planning for each patient; and (4) restructuring the current fees to allow for annual fees for both in-state and out-of-state patients, clinic certification fees based on the size of the clinic, and the ability to assess fines for noncompliance to provide revenue for increased regulatory oversight of the clinics.

Commission questions and discussion followed regarding moving patients off of

methadone and how to measure success in the treatment program. Success is currently measured by length of time in the treatment program. There were also questions regarding how the recommendations made by the Division compare to the regulation of programs in other states, discussion on individualized treatment plans, and take-home medications.

Cathy Boggs, Director, Division of Mental Health and Addiction, FSSA

Ms. Boggs reviewed the Division's progress with the Quality Initiative Service Review process and said the Division is moving to start surveying addictions providers. In response to a question about shifting the operation of the methadone clinics to the Department of Health as suggested by Dr. Kora, Ms. Boggs stated that a shift to not-for-profit operations would be preferable.

**Revision of the Agenda**

Rep. Charlie Brown, chairing the meeting for Sen. Patricia Miller, cited the length of time taken for the first agenda item and asked persons attending the meeting to testify for other agenda items that were not time-sensitive, if they could delay until another meeting. As a result of the delay, Exhibit #9, concerning the Indiana Eligibility Modernization Project, and Exhibits #10, #11, and #12 concerning state laws and ordinances restricting smoking were distributed but not discussed at this meeting. Rep. C. Brown agreed to hear two additional agenda items and requested that testimony be brief.

Rep. C. Brown asked Commission members to indicate if they would be unable to attend the October 2, 2007, Commission meeting in Gary for purposes of the Commission's budget.

**Private Insurance Parity with Medicare for Prosthetics**

Marifran Mattson, Indiana Amputee Insurance Protection Coalition

Ms. Mattson introduced herself and distributed a handout with draft bill language for mandated insurance coverage parity with Medicare benefits for prosthetic coverage. (See Exhibit #13.) She explained that after her physician recommended a specific prosthesis for her, her insurance company denied the application. She stated that insurance companies are imposing dollar caps and restrictions for prosthetics claims. She said that while many people would regard prosthetics as basic medical care for the individuals who need them, most people are not aware of the impact of coverage restrictions and the consequences associated with not getting the appropriate prosthetics. Ms. Mattson distributed a letter of support from the American Diabetes Association in support of the concept. (See Exhibit #14.)

Ms. Mattson stated that a state insurance mandate for parity with the Medicare program would cost approximately $0.12 to $0.35 per member per month, not taking into account any savings resulting from problems otherwise arising due to delays and denials of necessary prosthetic devices. She also commented that insurance parity would decrease cost shifting to the Veteran's Administration, Vocational Rehabilitation, Medicaid, and other government assistance programs.

Kent Turnbow, Indiana Amputee Insurance Protection Coalition

Mr. Turnbow introduced himself as an amputee and a prosthetist by profession. He commented that the technology involved in a prosthesis can influence the quality of life for the patient. He gave an example by comparing the $6,000 cost of a prosthetic that uses 30-year-old technology to that of $13,000 for the cost of a prosthetic that uses current technology. If an insurance policy is capped at $4,000 per year and the patient is working, often they will turn to vocational rehabilitation services offered by the state to obtain the prosthetic device needed.

Amy Mills

Ms. Mills, age 15, testified that she outgrows her prosthesis every 9 to 10 months. Her insurance carrier denied the latest claim three times before finally approving it, but paid only half the cost.

Commission questions followed on the cost involved and the average life of a prosthetic device. Mr. Turnbow responded that the average life of a prosthesis is about 3 years. However, some prosthetics can be repaired to extend the life of the device at about half the cost of a replacement.

Ann Doran, America's Health Insurance Plans

Ms. Doran commented that advocates always have a good reason why a benefit should be mandated. However, she stated that state mandates can only influence commercially sold policies which constitute only 29% of the insurance plans available. She added that the commercial sector of the market represents small businesses and individuals, the most price sensitive portion of the health insurance market. The remaining plans are self-funded and governed by federal law.

Commission discussion followed regarding the need for individuals to discuss this issue with employers, and that due to the federal statutes, Congress is the most appropriate body to be lobbied for mandated benefits. There was a question on what other costs might be incurred as a result of the denial or limitation of benefits by insurance carriers. Sen. Simpson asked for additional information about vocational rehabilitation services with regard to: coverage for prosthetics; the process and length of time for the process; and types of devices supplied.

Upon a question by the Chairperson, Ms, Carol Cutter, representing the Department of Insurance, reported that the Department has no position on this issue.

**Nurses in Schools**

Phyllis Lewis, MSN, Coordinator, Health Services, Department of Education

Ms. Lewis reported on the implementation of HEA 1116-2007, which requires schools to report on the number of students who have a chronic disease and the number of school nurses. Ms. Lewis reported that the information will be collected with the ADM count performed on December 3, 2007. The Department expects to report the results of the count by February 1, 2008. (See Exhibit #15.)

Mary Conway, RN, Indiana Association of School Nurses

Ms. Conway, RN, introduced herself as a school nurse working for Indianapolis Public Schools. She discussed the role of the school nurse and the changes in the practice over the 22 years that she has been employed as a school nurse. Ms. Conway discussed the needs of school children with chronic conditions such as diabetes and asthma. She also related that for a variety of reasons, a school nurse may be the only access to health care that many children may have. (See Exhibit #16.)

Jolene Bracale, RN, Indiana Association of School Nurses

Ms. Bracale, RN, introduced herself as a school nurse with 12 years of experience in school nursing. She discussed the role of the school nurse and identified positive impacts on students' educational experiences as a result of access to school nurses. She reported that the number of missed school days decline when there is a full-time nurse. She also reported that nationally there are 50% more 911 calls in schools that do not have school nurses. (See Exhibit #17.)

Commission discussion followed with regard to what options might be available to fund these services, how other states fund school nurse services, and the possibility of concentrating children with known health care needs into buildings where a nurse would be available.

Annette Marette, RN, BSN, Indiana Association of School Nurses

Ms. Marette waived her testimony due to time constraints.

The next meeting of the Health Finance Commission is at 10:00 AM Central Time (11:00 AM Eastern) at the Savannah Center Auditorium at IU Northwest in Gary, IN.

The meeting was adjourned at 4:15 PM.